South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Nursing
P.O. Box 12367 • Columbia, SC 29211
Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/nursing/

INSTRUCTIONS AND REQUIREMENTS FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) Application

(Updating from a current South Carolina RN License to SC APRN License)

Information for Applicant

South Carolina is a member of the Nurse Licensure Compact (NLC). The NLC does not affect additional requirements imposed by states for advanced-practice registered nursing. A multi-state licensure privilege to practice registered nursing granted by a party state must be recognized by other party states as a license to practice registered nursing if a license to practice registered nursing is required by state law as a precondition for qualifying for advanced-practice registered nurse authorization.

A current APRN South Carolina license or temporary license is required to practice advanced nursing in this state. Orientation is considered the practice of nursing in South Carolina. Therefore, all nurses must possess a current South Carolina license and/or temporary license before beginning orientation (including classroom instruction and reading policies and procedures). It is a violation of the Nurse Practice Act to begin orientation without the proper license and can result in action by the Board. Please visit our website at www.llr.state.sc.us/pol/nursing to review the complete South Carolina Nurse Practice Act, Section 40-33-34 for more details on educational and certification requirements.

Prior to completing application, review Section 40-33-34 of the Nurse Practice Act for statutory requirements for licensure as an Advanced Practice Registered Nurse (APRN) in South Carolina. The Nurse Practice Act can be found under Laws/Policies on our website www.llr.state.sc.us/pol/nursing/

If you were previously licensed by the SC Board of Nursing as an APRN, do not complete this application form. Go to www.llr.state.sc.us/pol/nursing for the APRN Reactivation/Reinstatement application.

Section 40-33-34(A)
An applicant for licensure as an Advanced Practice Registered Nurse (APRN) shall furnish evidence satisfactory to the board that the applicant:

(1) has met all qualifications for licensure as a registered nurse; and
(2) holds current specialty certification by a board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion; and
(3) has earned a master's degree from an accredited college or university, except for those applicants who:
    (a) provide documentation as requested by the board that the applicant was graduated from an advanced, organized formal education program appropriate to the practice and acceptable to the board before December 31, 1994; or
    (b) graduated before December 31, 2003, from an advanced, organized formal education program for nurse anesthetists accredited by the national accrediting organization of that specialty. CRNA's who graduate after December 31, 2003, must graduate with a master's degree from a formal CRNA education program for nurse anesthetists accredited by the national accreditation organization of the CRNA specialty. An advanced practice registered nurse must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty;
(4) has paid the board all applicable fees; and
(5) has declared specialty area of nursing practice and the specialty title to be used must be the title which is granted by the board-approved credentialing organization or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.

Prescriptive Authority: APRN's applying for prescriptive authority shall meet the requirements as noted in the S.C. Nurse Practice Act, Section 40-33-34 (E).

Instructions & Information

1. Complete and submit this application to the Board if you have a current SC RN license and want to update your RN license credential to a SC Advanced Practice Registered Nurse (APRN) license. **Application fees are non-refundable**. Money order, cashier's check or personal check should be made payable to **LLR-Board of Nursing**. Your application must include the following:

1. Recent 2"x 2" full faced passport type photo, sign and date on front or back and tape along top edge only onto your application.
2. Copy of current SC RN license with the expiration date.
3. Document of earned master's degree (§40-33-34) Have official transcripts sent directly from your master's from nursing educational program to Board of Nursing.
4. Copy of current specialty certification by a board-approved credentialing organization. (New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion).
5. Copies of legal documents that authorize a change in name, if applicable.
6. Obtain all physician signatures and license numbers to be included on your application, if applicable.
7. See the SC Nurse practice Act for guidelines on the development of written protocols.
8. Application fees – Money order, cashier's check or personal check made payable to LLR-Board of Nursing.
   $30.00 - Update from current SC RN license to APRN (Permanent license only)
   $40.00- Update from current SC RN license to APRN with temporary license
9. Applying for Prescriptive Authority-complete and submit**:**
   - Prescriptive Authority Application- see www.llr.state.sc.us/pol/nursing
   - Documentation of 45 continuing education hours in pharmacotherapeutics
10. Check the status of your application online at www.llr.state.sc.us/pol/nursing**.** Allow 10 business days for processing after receipt of your application in the board's office. Also allow 10 business days after receipt of the last document for a license number to be generated. During peak times, the application review/approval process may take longer.

2. Change of Address - The Board should be notified of all changes in address, name and/or telephone number. You must notify the Board in writing immediately after you file this application in order to receive information from the board.

3. Change in Supervising Physician or Place of Practice - It is of utmost importance that you inform the Board of any changes in your supervising physician or place of practice. The South Carolina Nurse Practice Act §40-33-34(D)(3) requires a licensed APRN who changes or discontinues primary practice settings or physician or dentist to notify the board of this change within 15 business days and provide verification of approved written guidelines. Failure to notify the Board of changes in practice shall be considered misconduct and subject the licensee to disciplinary action.

4. Name Used on License - All licenses are issued in the applicant's legal name. Your legal name is your first name, middle name or maiden name, if married, and last name. The name as it appears on your birth certificate will be printed on your license, unless it has been changed legally by marriage, divorce or other legal action. If your name changes (marriage, divorce or other court order) after the application has been filed, a certified copy of the legal document changing your name must be submitted to this office so that the correct name appears on the license. Your first name cannot be dropped and your middle name used on the license unless you have legally made this change and have provided documentation (court documents).

5. Notification of Initial Employment or Change of Practice -§40-33-34 (D)(3) & (H)(4) of the S.C. Nurse Practice Act requires that licensed APRN who change or discontinue practice settings or physician (or dentist) shall notify the Board of such change within 15 days and provide verification of approved written protocols (guidelines). Failure to notify the Board of a change in practice shall be considered misconduct and subject the licensee to disciplinary action.

6. License Renewal - South Carolina Nursing Licenses are renewed every even year. All licenses must be renewed by April 30th every even year. It is the responsibility of the licensee to renew their license. Do not wait until renewal time to notify the Board of a change in your address, supervisor or practice setting. See §40-33-40 of the Nurse Practice Act to review the competency requirements and §40-33-34(E)(3) for prescriptive authority requirements for renewal.

Remember:

- ☐ Prior to completing application, review Section 40-33-34 of the Nurse Practice Act for statutory requirements for licensure as an Advanced Practice Registered Nurse (APRN) in South Carolina. The Nurse Practice Act can be found under Laws/Policies on our website www.llr.state.sc.us/pol/nursing/
- ☐ If you were previously licensed by the SC Board of Nursing as an APRN, do not use this application form. Visit Applications/Forms on the Board's web page for a Reactivation/Reinstatement Application to reinstate your APRN license.
- ☐ Please print clearly in black ink.
- ☐ Complete the Affidavit of Eligibility.
- ☐ Cashier's check, money order or personal check should be made payable to LLR-Board of Nursing.
- ☐ Documents (marriage licenses and other legal documents) are part of your application file and are not returned.
- ☐ Notify the Board *immediately* of any change in name or address changes during the application process.
- ☐ Copies of legal documents that authorize a change in name.
- ☐ Sign, date your photo on the front or back and tape along the top edge only onto your application. Color or black and white photos are accepted.
- ☐ Criminal Background Check (CBC) - Board will forward instructions once application is received.
- ☐ Document of earned master's degree. Have official transcripts sent directly from your master's nursing educational program to the SC Board of Nursing.
- ☐ Supply a copy of a current advanced practice nursing specialty certification by board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion.
- ☐ See the SC Nurse Practice Act [§40-33-34] and the SC Medical Practice Act for guidelines on the development of written protocols.
- ☐ Obtain all SC physician signatures and license numbers to be included on your application, if applicable.
- ☐ **Check the status of your application online on the Board's website**. Once all requirements have been received, a license number may be generated within 10 business days. During peak times, the application review/approval process may take longer.
- ☐ Applications are maintained on file for one year; all fees are non-refundable.
- ☐ Applicants applying for Prescriptive Authority, complete and submit:
  - Prescriptive Authority Application- see www.llr.state.sc.us/pol/nursing
  - Documentation of continuing education hours in pharmacotherapeutics
  - Prescriptive authority will not be granted until the fee has been received, educational requirements are met; supervising physician signatures are obtained and proof of national certification has been received).
- ☐ Any questions regarding this application should be directed to the SC Board of Nursing at (803) 896-4550.

Criminal Background Check (CBC):

Effective March 2, 2009, an applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as defined in 40-33-25 of the Nursing Practice Act. The Board will send you instructions on how to have your fingerprints processed once your application is received

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APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE (APRN)
UPDATING FROM CURRENT SOUTH CAROLINA RN LICENSE TO SC APRN LICENSE

Complete all sections of this application by providing all of the requested information. Please print. Answer all questions and submit with proper fee. Careful completion of this application will avoid a delay in processing. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act. Personal information provided in this application may be subject to public scrutiny or release under the SC Freedom of Information Act or other provisions of federal and state law. The disclosure of the social security number for identification purposes is authorized and mandated by state and federal statutes. The social security number is not subject to disclosure as public information. The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

If you were previously licensed by the South Carolina Board of Nursing as an APRN, do not complete this application form. Visit the Board of Nursing Website at www.llr.state.sc.us/pol/nursing for APRN Reactivation/Reinstatement application to reinstate your APRN license.

Applying as: ☐ **Nurse Practitioner (NP)** ☐ **Certified Nurse-Midwife (CNM)** ☐ **Certified Registered Nurse Anesthetist (CRNA)** ☐ **Clinical Nurse Specialist (CNS)**

PART I: Applicant Identifying Information

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**

5. **Title** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	6. **Maiden Name**	7. **Social Security Number**

8. Mailing Address (Street or PO Box, City, State, Zip)

9. **Home Address** (Street, City, State, Zip – **not PO Box**)	9a. **County**

9b. **Home Phone**	9c. **Home Fax**	9d. **Home Email**

10. **Identify Preferred Mailing address.** ☐ Mailing ☐ Home

11. **Place of Birth** (City, State & Country)	12. **Date of Birth MM/DD/YYYY**	13. **Gender** ☐ Male ☐ Female	14. **Race (For Statistical Purposes Only)** ☐ African American/Black ☐ American Indian ☐ Asian ☐ Hispanic/Spanish Origin ☐ Caucasian/White ☐ Other

15. Have you ever been licensed in South Carolina? If yes, SC Registered Nurse (RN) License Number_____ **YES** ☐ **NO** ☐

16. **Declaration of Primary State of Residence**: (where I hold a driver's license, pay taxes or vote)

I declare my primary state of residence is _____I plan to primarily practice in the state of_____.

I am in the military or federal government. I am currently licensed in _____ (state) and I do not intend to work outside of military or federal government.

PART II: Education/Professional Education

List in chronological order from date of graduation to the present all professional education. Do not include continuing education coursework or clinical training.

SCHOOL /INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	
				Y☐ N☐	

Transcripts: Provide an official transcript sent directly to the board from your master's nursing education program. The application cannot be completely processed until we have the official transcript showing completion of a masters in nursing post masters or doctorate

College or University Accredited? Yes ☐ No ☐	**If yes, Accredited by:**
Graduate Nursing Program Accredited? Yes ☐ No ☐	

PART III: Record of Examination(s)

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination attempt below. Attach additional sheets if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination	State or Country	Date of Examination	Passed/Failed/Score (If score, enter score)
Specialty Certification Exam(s)	**Certifying Organization(s)**	**Original Date of Certification**	**Expiration Date of Certification**

PART IV: Record of Licensure

Complete the requested information below if you have ever been licensed, certified or registered to practice in any profession or occupation. You must identify the method by which you obtained **your** license(s) and include jurisdiction both within and outside the United States, current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (**Attach additional sheets if necessary**.)

Jurisdiction	Credential Type (LPN, RN or APRN)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date Issued
State of Original (Initial) Licensure:				
List Other Jurisdictions of Licensure:				

PART V: Employment History

List all related employment chronologically, most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable. Photocopy this page and attach if additional space is required.

1. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
2. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
3. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**
4. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
5. Employer Name	**Employer Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Dates of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for Leaving**

PART VI: Personal History Information

If you answer "**yes"** to any of the questions below (1-10), you must attach a full written explanation pertaining to that particular question.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority?	**YES** ☐ **NO** ☐
2. Have you ever been refused or denied the privilege of taking an examination required for any professional license?	**YES** ☐ **NO** ☐
3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility?	**YES** ☐ **NO** ☐
4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures?	**YES** ☐ **NO** ☐
5. To your knowledge have any unresolved or pending complaints ever been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic?	**YES** ☐ **NO** ☐
6. Have you ever been arrested, charged or convicted (including a nolo contender plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? **If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities.**	**YES** ☐ **NO** ☐
7. Currently are you being treated or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
8. Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
9. Currently or within the last five years, have you developed any disease or conditions, physical, mental, or emotional that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
10. a. Have you ever voluntarily surrendered a nursing license? b. Have you ever voluntarily surrendered a controlled substance or DEA registration?	**YES**☐ **NO** ☐ **NA**☐ **YES**☐ **NO** ☐ **NA**☐
11. a. Do you plan to prescribe Schedules III through V?	**YES**☐ **NO** ☐ **NA**☐

PART VII: Specialty Area(s) & Certification(s)

1. Specialty area of APRN practice.

2. Describe your specialty area in advanced nursing practice. **(**This section will be assessed by an Advanced Practice Nursing Consultant who will determine the closest scope of practice area in accordance with National Certification)

3. Do you hold current specialty certification by a national credentialing organization(s)? **YES** ☐ **NO** ☐

Certifying Organization_____

Expiration date_____(Attached a copy of certificate)

(New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program**.**

Other

Check here if you are trained and willing to volunteer your services during a bioterrorism disaster? **YES** ☐ **NO** ☐

Check here if you are trained and willing to volunteer your services during a disaster? **YES** ☐ **NO** ☐

PART VIII: Advanced Practice Employment (Current)

PRIMARY Practice Site (If more than 2 sites, duplicate form as needed)	Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):	
	Practice Address: (Street, City, State, Zip Code)	
Supervising Physician: ☐ Primary Physician ☐ Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing) Business Address: (Street, City, State, Zip)	Proximity to NP, CNM, CNS in Miles:
SC Physician's License No:	Practice Specialty:	Primary Practice Site Phone Number

_____ _____
Signature of Supervising Physician Date

By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

SECONDARY/ADDITIONAL Practice Site (If more than 2 sites, duplicate form as needed)	Employer Name:	
	Practice Address: (Street, City, State, Zip)	
Supervising Physician: ☐ Primary Physician ☐ Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing) Business Address: (Street, City, State, Zip)	Proximity to NP, CNM, CNS in Miles:
SC Physician's License No:	Practice Specialty:	Secondary Practice Site Phone Number

_____ _____
Signature of Supervising Physician Date

By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

A copy of practice protocols, for NP, CNM, or CNS/ copy of written approved guidelines for CRNA signed and dated by all the physicians listed above and myself are on file in the office/agency of my employment and available upon request. YES ☐ NO ☐

PART IX: Certifying Statement

I, _____ (**print name**), am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice nursing in South Carolina.

I hereby authorize the South Carolina Board of Nursing to utilize my Social Security Number (SSN) in making necessary reports to the National Council of State Boards of Nursing (NCSBN) data center for compilation of information about applicants and licenses in order to coordinate licensure and disciplinary activities between the individual states' licensing boards, and to federal and state entities, as required by law.

_____ _____
Applicant's Signature (Do not print) Date

Subscribed and sworn to before me this _____ day of _____,

20_____.

_____
Signature of Notary Public

My Commission Expires: _____

Tape photo at top **only**

Attach recent passport photo here

"2 x 2"

No copies

Sign and date photo

Do not staple

DID YOU REMEMBER TO:

- ☐ Complete and answer all questions. Sign, date and have application notarized.
- ☐ Complete the Affidavit of Eligibility (Next 2 pages)
- ☐ Sign, date your photo on front or back and tape along top edge only onto your application. Black & white photos are acceptable.
- ☐ Enclose non-refundable application fee - Money order, cashier's check or personal check made payable to **LLR-Board of Nursing. No cash accepted.**

  $30.00 - Update from current SC RN license to APRN (Permanent license only).
  $40.00- Update from current SC RN license to APRN and temporary license.

- ☐ Copy of current SC RN License.
- ☐ Document of earned master's degree (See Nurse Practice Act). Have official transcripts sent directly from your master's of nursing educational program to Board of Nursing.
- ☐ Criminal Background Check(CBC) - Board will forward instructions once application is received
- ☐ Copy of current specialty certification by a board-approved credentialing organization. (New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion).
- ☐ See the SC Nurse practice Act for guidelines on the development of written protocols
- ☐ Obtain all physician signatures and license numbers to be included on your application, if applicable.
- ☐ If applying for Prescriptive Authority, complete and submit:
  - Prescriptive Authority Application- see SC BON web site www.llr.state.sc.us/pol/nursing
  - Documentation of continuing education hours in pharmacotherapeutics (prescriptive authority will not be granted until the fee has been received, educational requirements are met; supervising physician signatures are obtained and proof of national certification has been received).
- ☐ Copies of legal documents that authorize a change in name.
- ☐ **Check the status of your application online** at www.llr.state.sc.us/pol/nursing**.** Once all requirements have been received, a license number may be generated within 10 business days. During peak times, the application review/approval process may take longer.

For Office Use Only
Paid by: ☐Check ☐Money Order
Check/Money Order No: _____
Amount: _____ Control No. _____

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or

2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or

3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.

4. ☐ Other:_____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See Instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

_____
Signature of Affiant

SWORN to before me this _____ day of _____

_____

Notary Public for _____

My Commission Expires: _____

I

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-688)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)